

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10619
Reg. Dist. No. 13

FOR STATE HEALTH DEPT.

10618

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>520 TRAIL AVE.</u>		e. STREET ADDRESS <u>520 TRAIL AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRAYSON STEINSRING Abrecht</u>		4. DATE OF DEATH Month Day Year <u>10 / 21 / 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NILES A. ABRECHT</u>		14. MOTHER'S MAIDEN NAME <u>Josephine F. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-1432</u>	
17. INFORMANT Address <u>520 Trail Ave.</u> <u>Mrs. Grayson S. Abrecht-Frederick-Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>10-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		24a. REC'D BY REGISTRAR DATE <u>23 Oct 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/21/57</u>	

RECEIVED

OCT 24 1957

BUREAU Y. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10620

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>23 1/2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Middletown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial</u>			d. STREET ADDRESS <u>Linden Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vallie</u> Middle <u>A</u> Last <u>Beachley</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alfred Kelly</u>			14. MOTHER'S MAIDEN NAME <u>Gemma Monigan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Heleh Zimmerman Park Ave. Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Second and Third Degree Burns</u> <u>9160</u> DUE TO arm, legs, & trunk (75% of body) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>25 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clothing accidentally caught fire</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9:30</u> <u>Oct. 16</u> <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Middletown</u>		20g. (County) <u>Frederick</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Bernard P. Thomas Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct. 17, 1957</u>	
EXAMINER'S NAME (Type) <u>Bernard P. Thomas Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Myersville</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown Md.</u>		ADDRESS <u>Gladhill Co., Middletown Md.</u>		24a. REC'D BY REGISTRAR <u>Elizabeth G. Heck</u>	
24b. REGISTRAR'S SIGNATURE					

STATE OF OHIO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10621

Item 18 Film 222 11-8-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville- rural		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville-- rural	
3. NAME OF DECEASED (Type or print) First Middle Last Carroll Franklin Bittner		4. DATE OF DEATH Month Day Year October 22 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1951
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Bittner		14. MOTHER'S MAIDEN NAME Louise M. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Robert E. Bittner		Address Sabillasville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brown Tumor; Malignant 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH approx 9 Mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 52 to Oct 22 , 19 57 that I last saw the deceased alive on Oct 21 , 19 57 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Kiefer M.D. Blue Ridge Summit, Pa. 22085		DATE SIGNED	
PHYSICIAN'S NAME (Type) Robert A. Kiefer M.D.		Blue Ridge Summit, Penna.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-24-57	22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR OCT 25 '57		24b. REGISTRAR'S SIGNATURE Reverend	

CERTIFICATE OF DEATH

W. J. B. 100

W. J. B. 100

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
Robert A. Hester		Male		35		1921		Louisiana		Baton Rouge		Louisiana		United States	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
None		None		None		None		None		None		None			
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION			
None		None		None		None		None		None		None			
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH			
None		None		None		None		None		None		None			
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH			
None		None		None		None		None		None		None			
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED			
None		None		None		None		None		None		None			
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS			
None		None		None		None		None		None		None			
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN			
None		None		None		None		None		None		None			
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER			
None		None		None		None		None		None		None			

BUREAU V. 3

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10622
731

10620

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>06x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>06x2.2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE</u> <u>John</u> <u>E.</u> <u>Blowhorn</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>31</u> <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George W. Blowhorn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Magers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-09-9032</u>		17. INFORMANT Address <u>Mrs. Bessie Blowhorn, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive Heart Failure</u> DUE TO (b) <u>Chronic Mitral Stenosis</u> DUE TO (c) <u>Chronic Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>yes</u> <u>yes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 28</u> , 19 <u>57</u> , to <u>Oct 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>57</u> , and that death occurred at <u>6:20</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md</u> DATE SIGNED <u>Oct 31, 1957</u>							
ACTUAL SIGNATURE <u>A. A. Pearre</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A. A. PEARRE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>				ADDRESS <u>Winfield, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ely Hicks</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>15. SIGNATURE OF DECEASED [Faint text]</p>		<p>16. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>25. SIGNATURE OF DECEASED [Faint text]</p>		<p>26. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>29. SIGNATURE OF DECEASED [Faint text]</p>		<p>30. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>33. SIGNATURE OF DECEASED [Faint text]</p>		<p>34. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>35. SIGNATURE OF DECEASED [Faint text]</p>		<p>36. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>39. SIGNATURE OF DECEASED [Faint text]</p>		<p>40. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>45. SIGNATURE OF DECEASED [Faint text]</p>		<p>46. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>47. SIGNATURE OF DECEASED [Faint text]</p>		<p>48. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>49. SIGNATURE OF DECEASED [Faint text]</p>		<p>50. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>51. SIGNATURE OF DECEASED [Faint text]</p>		<p>52. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>55. SIGNATURE OF DECEASED [Faint text]</p>		<p>56. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>57. SIGNATURE OF DECEASED [Faint text]</p>		<p>58. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>59. SIGNATURE OF DECEASED [Faint text]</p>		<p>60. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>63. SIGNATURE OF DECEASED [Faint text]</p>		<p>64. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>65. SIGNATURE OF DECEASED [Faint text]</p>		<p>66. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>69. SIGNATURE OF DECEASED [Faint text]</p>		<p>70. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>75. SIGNATURE OF DECEASED [Faint text]</p>		<p>76. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>77. SIGNATURE OF DECEASED [Faint text]</p>		<p>78. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>85. SIGNATURE OF DECEASED [Faint text]</p>		<p>86. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>87. SIGNATURE OF DECEASED [Faint text]</p>		<p>88. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>93. SIGNATURE OF DECEASED [Faint text]</p>		<p>94. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>95. SIGNATURE OF DECEASED [Faint text]</p>		<p>96. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF WITNESSES [Faint text]</p>	

BUREAU V. S.

NOV 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

10621

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>403 Wilson Place</u>	
3. NAME OF DECEASED (Type or print) <u>BRENDA LEE BLUMENAUER</u>		4. DATE OF DEATH <u>October 30 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1957</u>
9. AGE (In years last birthday) yrs. <u>194</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lee Blumenauer</u>		14. MOTHER'S MAIDEN NAME <u>Betty Jane Kauffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MOTHER Mrs Betty Blumenauer</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>fetal atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>from m. with</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/29, 1957</u> , to <u>10/30, 1957</u> , that I last saw the deceased alive on <u>10/30, 1957</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James B. Thomas</u>		ADDRESS (Street, city or town, state) <u>Frederick, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JAMES B. THOMAS</u>		DATE SIGNED <u>10/31/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey</u>		24a. REC'D BY REGISTRAR <u>DATE 1 Nov 1957</u>	
ADDRESS <u>Frederick, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heisk</u>	

2069211XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION		13. CAUSE OF DEATH		14. MANNER OF DEATH		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS		61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
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81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS		91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS		103. SIGNATURE OF WITNESS		104. SIGNATURE OF WITNESS	
105. SIGNATURE OF WITNESS		106. SIGNATURE OF WITNESS		107. SIGNATURE OF WITNESS		108. SIGNATURE OF WITNESS		109. SIGNATURE OF WITNESS		110. SIGNATURE OF WITNESS		111. SIGNATURE OF WITNESS		112. SIGNATURE OF WITNESS	
113. SIGNATURE OF WITNESS		114. SIGNATURE OF WITNESS		115. SIGNATURE OF WITNESS		116. SIGNATURE OF WITNESS		117. SIGNATURE OF WITNESS		118. SIGNATURE OF WITNESS		119. SIGNATURE OF WITNESS		120. SIGNATURE OF WITNESS	
121. SIGNATURE OF WITNESS		122. SIGNATURE OF WITNESS		123. SIGNATURE OF WITNESS		124. SIGNATURE OF WITNESS		125. SIGNATURE OF WITNESS		126. SIGNATURE OF WITNESS		127. SIGNATURE OF WITNESS		128. SIGNATURE OF WITNESS	
129. SIGNATURE OF WITNESS		130. SIGNATURE OF WITNESS		131. SIGNATURE OF WITNESS		132. SIGNATURE OF WITNESS		133. SIGNATURE OF WITNESS		134. SIGNATURE OF WITNESS		135. SIGNATURE OF WITNESS		136. SIGNATURE OF WITNESS	
137. SIGNATURE OF WITNESS		138. SIGNATURE OF WITNESS		139. SIGNATURE OF WITNESS		140. SIGNATURE OF WITNESS		141. SIGNATURE OF WITNESS		142. SIGNATURE OF WITNESS		143. SIGNATURE OF WITNESS		144. SIGNATURE OF WITNESS	
145. SIGNATURE OF WITNESS		146. SIGNATURE OF WITNESS		147. SIGNATURE OF WITNESS		148. SIGNATURE OF WITNESS		149. SIGNATURE OF WITNESS		150. SIGNATURE OF WITNESS		151. SIGNATURE OF WITNESS		152. SIGNATURE OF WITNESS	
153. SIGNATURE OF WITNESS		154. SIGNATURE OF WITNESS		155. SIGNATURE OF WITNESS		156. SIGNATURE OF WITNESS		157. SIGNATURE OF WITNESS		158. SIGNATURE OF WITNESS		159. SIGNATURE OF WITNESS		160. SIGNATURE OF WITNESS	
161. SIGNATURE OF WITNESS		162. SIGNATURE OF WITNESS		163. SIGNATURE OF WITNESS		164. SIGNATURE OF WITNESS		165. SIGNATURE OF WITNESS		166. SIGNATURE OF WITNESS		167. SIGNATURE OF WITNESS		168. SIGNATURE OF WITNESS	
169. SIGNATURE OF WITNESS		170. SIGNATURE OF WITNESS		171. SIGNATURE OF WITNESS		172. SIGNATURE OF WITNESS		173. SIGNATURE OF WITNESS		174. SIGNATURE OF WITNESS		175. SIGNATURE OF WITNESS		176. SIGNATURE OF WITNESS	
177. SIGNATURE OF WITNESS		178. SIGNATURE OF WITNESS		179. SIGNATURE OF WITNESS		180. SIGNATURE OF WITNESS		181. SIGNATURE OF WITNESS		182. SIGNATURE OF WITNESS		183. SIGNATURE OF WITNESS		184. SIGNATURE OF WITNESS	
185. SIGNATURE OF WITNESS		186. SIGNATURE OF WITNESS		187. SIGNATURE OF WITNESS		188. SIGNATURE OF WITNESS		189. SIGNATURE OF WITNESS		190. SIGNATURE OF WITNESS		191. SIGNATURE OF WITNESS		192. SIGNATURE OF WITNESS	
193. SIGNATURE OF WITNESS		194. SIGNATURE OF WITNESS		195. SIGNATURE OF WITNESS		196. SIGNATURE OF WITNESS		197. SIGNATURE OF WITNESS		198. SIGNATURE OF WITNESS		199. SIGNATURE OF WITNESS		200. SIGNATURE OF WITNESS	

BUREAU V. S.

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624

10622

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Lincoln Apts.				d. STREET ADDRESS 8 Lincoln Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry A. Last Boyd				4. DATE OF DEATH Month Oct. Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH June 4-1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME David Boyd				14. MOTHER'S MAIDEN NAME Maria Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 100-100000		17. INFORMANT Mrs. Wm. H.A. Boyd-8 Lincoln Apts.-Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Hour year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/17 , 19 56 , to 10/3 , 19 57 , that I last saw the deceased alive on 9/10 , 19 57 , and that death occurred at 11P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 10-5-1957							
ACTUAL SIGNATURE James B. Thomas M.D. Frederick-Maryland							
PHYSICIAN'S NAME (Type) Dr. James B. Thomas Frederick-Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) E. of Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR Oct 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck			

BUREAU V. S.

1957 8 OCT

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10626

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-New Windsor-Rt.2		c. LENGTH OF STAY IN lb Two weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-New Windsor-Rt.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Ellen Last Browning				4. DATE OF DEATH Month Oct. Day 28 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> Never married		8. DATE OF BIRTH July 8-1921	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min. 36		IF UNDER 24 HRS. Months 36 Days 36 Hours 36 Min. 36			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Herbert Breedon(deceased)				14. MOTHER'S MAIDEN NAME Flora Hurt Breedon(living)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Not available		17. INFORMANT Address George Shaffer- New Windsor, Md. Rt. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. B.O. Thomas-Sr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Oct. 29, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-29-1957		22c. NAME OF CEMETERY OR CREMATORY c/o Anatomical Board		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR 30 Oct 1957	
24b. REGISTRAR'S SIGNATURE Ely. H. H. S.							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10-1-1951		Home	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
123 Main St.		Teacher		Heart Disease		Natural		10:00 AM		[Signature]	
City		State		County		District		Parish		Territory	
Baltimore		Maryland		Baltimore		District		Parish		Territory	
Date of Birth		Date of Death		Time of Death		Place of Death		Signature of Examiner		Signature of Coroner	
10-1-1951		10-1-1951		10:00 AM		Home		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10627

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Pleasant		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle Lee Last Burrier		4. DATE OF DEATH Month October Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66	IF UNDER 24 HRS. Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Burrier		14. MOTHER'S MAIDEN NAME Mollie Fogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 212-I4-6840	
17. INFORMANT William Mullican		Address Mt Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of left lung 975x DUE TO Conditions, if any, which gave rise to immediate cause (b) Due to gun shot wound into left lung (c) Minutes DUE TO (a) stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot wound in let lung	
20c. TIME OF INJURY Month, Day, Year 10 5 10/5/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mt Pleasant Frederick Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 6, 1957	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Chapel Cemetery		22b. DATE THEREOF Oct 8 1957	
22c. NAME OF CEMETERY OR CREMATORY Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Liberty Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Walker		ADDRESS Walkersville, Md.	
24a. REC'D BY REGISTRAR 9 Oct. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

RECEIVED

OCT 10 1957

BUREAU V. B.

10653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Frederick</u> <u>Brunswick</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick, Maryland</u> <u>35</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>514 Brunswick Street</u>		d. STREET ADDRESS <u>514 Brunswick Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Edgar C.</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 - 12 - 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Landon Carter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hoffmaster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-12-5809</u>	
17. INFORMANT <u>Mrs. Margaret Carter</u>		Address <u>Brunswick, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Hypertension</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 19, 1957</u> , to <u>Oct. 23, 1957</u> , that I last saw the deceased alive on <u>Oct. 9, 1957</u> , and that death occurred at <u>6:22</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Brunswick, Md. - 10/23/57</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Brownsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva V. Teeter</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>28 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Eugenia Purkey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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10624

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film G221 10-18-57 et

10624

CERTIFICATE OF DEATH

10629

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Three Pines Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STERLEY EDWIN CRUM</u>				4. DATE OF DEATH Month Day Year <u>Oct. 9 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23 1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John David Crum</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Cresger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, list, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-32-5304</u>		17. INFORMANT Address <u>Mrs Helen Mesbaum, Mt Airy, RI, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work _____ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____ 21. I certify that I attended the deceased from <u>Oct. 9, 1957</u> , to <u>Oct. 9, 1957</u> , that I last saw the deceased alive on <u>Oct 9, 1957</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert S. Turner, Jr.</u> M.D. ADDRESS (Street, city or town, state) <u>7 E. Church St. Frederick, 10-11-57</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>ROBERT S. TURNER, JR</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10/10/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Mr. Libertytown Md.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u> ADDRESS <u>Walkersville, Md</u> 24a. REC'D BY REGISTRAR <u>Elizabeth G. Heck</u> 24b. REGISTRAR'S SIGNATURE <u>14 Oct 1957</u>							

RECEIVED

OCT 16 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF WITNESS
14. SIGNATURE OF DECEASED
15. SIGNATURE OF NEXT OF KIN
16. SIGNATURE OF BURIAL SOCIETY
17. SIGNATURE OF FUNERAL HOME
18. SIGNATURE OF CHURCH
19. SIGNATURE OF CEMETERY
20. SIGNATURE OF OTHER

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10625

CERTIFICATE OF DEATH

10630

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 306 Upper College Terrace	
3. NAME OF DECEASED (Type or print) First KATHARINE Middle KAUFMAN Last DERTZBAUGH		4. DATE OF DEATH Month October Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 March 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Kaufman		14. MOTHER'S MAIDEN NAME Fannie Houck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank M. Dertzbaugh		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 30, 1957 , to Oct 20, 1957 , that I last saw the deceased alive on Oct 20, 1957 , and that death occurred at 1:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md. DATE SIGNED 10-21-57	
PHYSICIAN'S NAME (Type) A. Austin Pearre, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS 4 E. Church St., Frederick, Md.	
24a. REC'D BY REGISTRAR 21 Oct 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

69

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CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1912		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Carpenter		High School		Married		Catholic		White		White		5' 8"		160 lbs	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Heart Disease		Natural		3 weeks		10/20/57		BALTIMORE		MD		MD		USA	
DETAILS OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		NAMES OF PHYSICIANS		HOSPITAL		NAMES OF SURGEONS		HOSPITAL		NAMES OF ASSISTANTS	
Chest pain, shortness of breath		None		Medicine		Dr. J. H. Smith		St. Mary's		Dr. J. H. Smith		St. Mary's		Dr. J. H. Smith	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
10/20/57		BALTIMORE		MD		MD		USA		10/20/57		BALTIMORE		MD	

BUREAU V. S.
OCT. 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10626

CERTIFICATE OF DEATH

Reg. Dist. No.

10631
131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 Wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 20 West 6th Street			
3. NAME OF DECEASED (Type or print) First Middle Last Horace Stanley Dorsey				4. DATE OF DEATH Month Day Year October 27 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6 - 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant Helper				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) New Market Fred. Co. Md.	
13. FATHER'S NAME Abraham Dorsey				14. MOTHER'S MAIDEN NAME Mary Gant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W.1				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Frederick, Md Mary E. Dorsey 176 W. All Saints St.	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic cardio vascular disease DUE TO (c) 10 Yrs.						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 27, 1957 to Oct 27, 1957 , that I last saw the deceased alive on Oct 27, 1957 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H.F. Kline				ADDRESS (Street, city or town, state) 7 North Market Street Frederick, Md.			
PHYSICIAN'S NAME (Type) H.F. Kline MD.				DATE SIGNED Oct 29 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct-30-57		22c. NAME OF CEMETERY OR CREMATORY Simpsons		22d. LOCATION (City, town, or county) (State) New Market Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles E. Hicks 111 Frederick, Md.				24a. REC'D BY REGISTRAR 30 Oct 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
J. Edgar Hoover		47		Male		White		Jan 7 - 1902		Jan 8 - 1953		Washington, D.C.		Washington, D.C.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
John Edgar Hoover		Mary A. Hoover		Lawyer		Homemaker		Jan 1, 1875		Jan 1, 1875		Jan 1, 1950		Jan 1, 1950	
EDUCATION		MARRIAGE		PREVIOUS MARRIAGES		CAUSE OF DEATH		PERIOD OF ILLNESS		ATTENDING PHYSICIAN		PLACE OF BURIAL		DATE OF BURIAL	
Harvard University		Married		None		Heart Disease		Several weeks		Dr. J. Edgar Hoover		Arlington National Cemetery		Jan 10, 1953	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10627

CERTIFICATE OF DEATH

Reg. Dist. No.

10632

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 East South Street				d. STREET ADDRESS 12 East South Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle Rebecca Last Duvall				4. DATE OF DEATH Month Oct. Day 3 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. ***** NEVER MARRIED <input checked="" type="checkbox"/> *****		8. DATE OF BIRTH July 27-1868	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min.		IF UNDER 24 HRS. Months 89 Days 89 Hours 89 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher-(retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Luther Duvall				14. MOTHER'S MAIDEN NAME Mary Hilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Walter H. Duvall-12 E. South St.-Frederick-Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1 19 57 , to Oct. 2- 19 57 , that I last saw the deceased alive on Oct. 2- 19 57 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 E. Church Street DATE SIGNED Oct. 4-1957 ACTUAL SIGNATURE H. J. Slusher M.D. PHYSICIAN'S NAME (Type) Dr. H. J. Slusher Frederick- Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 6-1957			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Frederick Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick-Maryland			
24a. REC'D BY REGISTRAR 7 Oct 1957				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

CERTIFICATE OF DEATH

1. NAME OF DECEASED FREDERICK		2. SEX Male		3. AGE 65	
4. PLACE OF BIRTH Princeton, New Jersey		5. DATE OF BIRTH July 27, 1908		6. DATE OF DEATH Oct. 1, 1957	
7. PLACE OF DEATH 12 East Tower Street, Baltimore, Md.		8. CAUSE OF DEATH Myocardial infarction		9. MANNER OF DEATH Natural	
10. NAME OF PHYSICIAN Dr. H. H. Johnson		11. NAME OF HOSPITAL None		12. NAME OF FUNERAL HOME None	
13. NAME OF NEXT OF KIN Mrs. H. H. Johnson		14. ADDRESS OF NEXT OF KIN 12 East Tower Street, Baltimore, Md.		15. CITY AND STATE Baltimore, Md.	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF REGISTRAR	

BUREAU V. S.

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10663
CERTIFICATE OF DEATH

10633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg rural		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES First C Middle FITZGERALD Last		4. DATE OF DEATH Oct. Month 3 Day 1957 Year	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A.V. Keepers		14. MOTHER'S MAIDEN NAME Mary Elizabeth Seabold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank Fitzgerald		Address Emmitsburg, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertensive arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiovascular disease DUE TO years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-14-54 , 19 54 , to 4/22 , 19 57 , that I last saw the deceased olive on 4/22 , 19 57 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Emmitsburg Md DATE SIGNED 10-4-57			
ACTUAL SIGNATURE Charles R Williams M.D.		PHYSICIAN'S NAME (Type) Charles R Williams Emmitsburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-57	
22c. NAME OF CEMETERY OR CREMATORY St. Anthony Cemetery		22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE OCT 8 '57		24b. REGISTRAR'S SIGNATURE W. H. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED A. V. Rogers		SEX Male		AGE 30 yrs.		DATE OF DEATH Feb. 20, 1937		PLACE OF DEATH Home	
MARRIAGE Married		EDUCATION High School		OCCUPATION None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
BIRTH Jan. 10, 1907		PLACE OF BIRTH Maryland		PARENTS John A. Rogers, Father Mary A. Rogers, Mother		SIBLINGS None		PREVIOUS ILLNESS None	
DATE OF DEATH Feb. 20, 1937		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. A. Rogers	
DATE OF DEATH Feb. 20, 1937		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. A. Rogers	

BUREAU V. S.

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10634

10628

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b x2 R.D. # 4 Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First STELLA Middle FRITZ Last FRITZ		4. DATE OF DEATH Month Oct. Day 6 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?? 1924
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Arthur Sirk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Norman Duvall, R.D. Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of ovary DUE TO (c) > 6 mos		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4 Oct. 1957 to 6 Oct. 1957 , that I last saw the deceased alive on 6 Oct. 1957 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert H. Pilgram M.D.		DATE SIGNED Frederick, Md. 10/6/57	
PHYSICIAN'S NAME (Type) Robert H. Pilgram, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-9-1957	22c. NAME OF CEMETERY Locust Grove	22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR OCT 9 1957		24b. REGISTRAR'S SIGNATURE Elmer E. Hicks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 9 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10629

CERTIFICATE OF DEATH

10635

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle MARGARET Last FRY				4. DATE OF DEATH Month October Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 1, 1892	
9. AGE (In years lost birthday) yrs. 65		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Jacob H. Fry			
14. MOTHER'S MAIDEN NAME Brances Payne				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 196-26-9366				17. INFORMANT Mrs. Oscar Gosnell, 21 West South Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic bronchitis + emphysema 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from April , 19 53 , to Oct 30 , 19 57 , that I last saw the deceased alive on Oct. 30 , 19 57 , and that death occurred at 2:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 11/1/1957							
ACTUAL SIGNATURE Dr. Rex R. Martin				PHYSICIAN'S NAME (Type) Dr. Rex R. Martin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Knoxville Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 4 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth L. H. H.	

CERTIFICATE OF DEATH

NAME - LAST, FIRST, MIDDLE DECEASED		SEX MALE	
DATE OF BIRTH JANUARY 1, 1892		PLACE OF BIRTH NEWTON, MASSACHUSETTS	
DATE OF DEATH NOVEMBER 5, 1957		PLACE OF DEATH NEWTON, MASSACHUSETTS	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH CORONARY THROMBOSIS	
PLACE OF DEATH HOME		MANNER OF DEATH NATURAL	
NAME OF PHYSICIAN DR. J. W. BROWN		NAME OF FUNERAL HOME J. W. BROWN	
NAME OF NEXT OF KIN MRS. J. W. BROWN		NAME OF BURIAL PLACE NEWTON CEMETERY	
NAME OF REGISTRAR J. W. BROWN		NAME OF CLERK J. W. BROWN	

BUREAU V. S.

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10630

10636

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Petersville x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Gertrude Last Frye		4. DATE OF DEATH 10 Month 2 Day 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonza Snoots		14. MOTHER'S MAIDEN NAME Katie B. Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Lewis Elmer Frye, Knoxville, Maryland	
17. INFORMANT Mr. Lewis Elmer Frye, Knoxville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 yr 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1 , 19 57 , to 10-2 , 19 57 , that I last saw the deceased alive on 10-2 , 19 57 , and that death occurred at 4 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Stone		ADDRESS (Street, city or town, state) 4 W 3rd St Frederick	
PHYSICIAN'S NAME (Type) Thomas E. Stone		DATE SIGNED 10-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-4-57	22c. NAME OF CEMETERY OR CREMATORY Lutheran	22d. LOCATION (City, town, or county) (State) Jefferson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt		24a. REC'D BY REGISTRAR Oct 9 1957	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Ely G. Felt	

BUREAU V. S.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10664

CERTIFICATE OF DEATH

10637

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEMPTOWN		c. LENGTH OF STAY IN 1b 4 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS X2 KEMPTOWN	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE GALLEY		4. DATE OF DEATH Month Day Year OCT 5 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30 - 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS COLES		14. MOTHER'S MAIDEN NAME MARIE COLES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT REV STEPHEN GALLEY		Address KEMPTOWN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease 416X Thyrototoxicosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 25 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis - acute			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1935 , 19____, to Oct. 5, 1957 , that I last saw the deceased alive on Oct. 5, 1957 , 19____, and that death occurred at 8 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Oct. 6, 1957			
ACTUAL SIGNATURE M. McKendree Boyer, M.D.		Druid Theatre Building, Damascus, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT 9 - 1957	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) WASHINGTON D C
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler		24a. REC'D BY REGISTRAR DATE OCT 9 1957	
ADDRESS Long Union Bridge, Md		24b. REGISTRAR'S SIGNATURE Lucian K. Salomey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

OCT 9 1957

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

1 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

10631

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Fredrick</u>		STATE <u>Md</u>		COUNTY <u>Fredrick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		<u>3 yrs</u>		TOWN <u>Keymar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>John Hyden Primes</u>				<u>10-3-57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 5, 1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Hess</u>		9. AGE last birthday <u>78</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Primes</u>				14. MOTHER'S MAIDEN NAME <u>Esther Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-32-1178</u>		17. INFORMANT & ADDRESS <u>Juliet E. Repk Below ave</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
431X IMMEDIATE CAUSE (A) <u>Heart Murmur</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gastric Ulcer</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 6, 1957</u> , to <u>Oct 3, 1957</u> , that I last saw the deceased alive on <u>Oct 2, 1957</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. H. Legg</u> M.D.				ADDRESS (Street, City, town, state) <u>Union Bridge Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 6-57</u>		NAME OF CEMETERY OR CREMATORY <u>Haugh's Cemetery</u>		LOCATION (City, town or county) (State) <u>Near Keymar Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Leslie L. Repk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond K. Wright</u>		ADDRESS <u>Union Bridge Md.</u>	
DATE <u>10/5/57</u>							

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10632-10665

10665

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville		c. LENGTH OF STAY IN 1b 8 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Rural- Myersville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Route # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) CHARLES UPTON GROSSNICKLE			4. DATE OF DEATH Month October Day 28 Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1856		9. AGE (In years last birthday) yrs. 101
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own gen. farm	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elias Grossnickle			14. MOTHER'S MAIDEN NAME Nancy Stottlemeyer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT R. Glen Grossnickle, Myersville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from Aug 10, 1957 to Oct 28, 1957 , that I last saw the deceased alive on Oct 24, 1957 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown DATE SIGNED 10-29-57					
ACTUAL SIGNATURE J. Elmer Harp		PHYSICIAN'S NAME (Type) J. Elmer Harp Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Grossnickle's	22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.	24a. REC'D BY REGISTRAR 10/30/57	24b. REGISTRAR'S SIGNATURE Hay M. Bittle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 100

OCT 21 1957

RECEIVED

BUREAU X. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10632 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Film G-222 -10/29/57.cac

CERTIFICATE OF DEATH

10640
Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Unk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Frederick Memorial Hospital		d. STREET ADDRESS Near Araby	
3. NAME OF DECEASED (Type or print) First CHARLES Middle RANDOLPH Last HARMON		4. DATE OF DEATH Month October Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1896
9. AGE (In years last birthday) 61/60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Owner-Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Harmon		14. MOTHER'S MAIDEN NAME Theela E. Dodson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Katherine S. Harmon, Frederick R.F.D.#2, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 9, 1957 to Oct. 12, 1957 , that I last saw the deceased alive on October 9, 1957 , and that death occurred at 1:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 E. Church St., Frederick, Md. DATE SIGNED 10-12-57 ACTUAL SIGNATURE H. J. Slusher M.D. PHYSICIAN'S NAME (Type) H. J. Slusher, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 15 Oct 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10633

CERTIFICATE OF DEATH

Reg. Dist. No.

10641

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Alvey Middle T. HOLMES		4. DATE OF DEATH Month Oct Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1879
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Holmes		14. MOTHER'S MAIDEN NAME Maggie -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-09-9136	
17. INFORMANT Mrs. Cora Holmes Address RFD # 1, Keedysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 27, 1957 , to Oct 28, 1957 , that I last saw the deceased alive on Oct 28, 1957 , and that death occurred at 7:57 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A.A. Pearre		DATE SIGNED 10/28/57	
PHYSICIAN'S NAME (Type) A.A. PEARRE		ADDRESS (Street, city or town, state) Frederick, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/57	22c. NAME OF CEMETERY OR CREMATORY Samples Manor	22d. LOCATION (City, town, or county) (State) Samples Manor, Washington, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ronald Zuckler		24a. REC'D BY REGISTRAR 31 Oct 1957	
ADDRESS Harpers Ferry, W.Va.		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb	

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX Male	
DATE OF BIRTH JAN 5, 1928		AGE 29	
PLACE OF BIRTH MOBILE, ALABAMA		RACE White	
OCCUPATION None		MARITAL STATUS Single	
DATE OF DEATH APR 4, 1968		TIME OF DEATH 11:00 AM	
PLACE OF DEATH MOBILE, ALABAMA		CAUSE OF DEATH Gunshot wound	
MEDICAL HISTORY None		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF BURIAL OFFICIAL [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

RECEIVED

NOV 1 1967

BUREAU V. 4

10634

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 West South St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle William Last Hooper				4. DATE OF DEATH Month October Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARITAL STATUS WIDOWED		8. DATE OF BIRTH Jan. 9-1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William O. Hooper			
14. MOTHER'S MAIDEN NAME Mary M. Simmons				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 220-10-5585				17. INFORMANT Joseph O. Hooper-624 Schley Ave.-Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 161X DUE TO Cardiomegaly of the Larynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Minutes 3 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____, 1956, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE James B. Thomas M.D. _____ Professional Bldg. PHYSICIAN'S NAME (Type) Dr. James B. Thomas Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C E Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 1 Nov 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Hesk							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

10666

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Jefferson				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last HOUP				4. DATE OF DEATH Month October Day 2 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Nov 1872	
9. AGE (In years by birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Martin Luther Houpt				14. MOTHER'S MAIDEN NAME Mary Jane Pearl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Annie M. Corun (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 794X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-2-1957 to 10-2-1957 that I last saw the deceased alive on 9-2-1957 , and that death occurred at 8:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church St., Frederick, Md. DATE SIGNED 10-3-57							
ACTUAL SIGNATURE Rex R. Martin				PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-4-57		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	
22d. LOCATION (City, town, or county) (State) Jefferson, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR 4 Oct 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH OCTOBER 1957	
NAME OF DECEASED [Name]		SEX [Male/Female]	
AGE [Age]		RACE [Race]	
PLACE OF BIRTH [Place]		DATE OF BIRTH [Date]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]	
PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
DATE OF SIGNATURE [Date]		DATE OF SIGNATURE [Date]	

BUREAU V. S.

OCT 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10644

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John William House</u>		4. DATE OF DEATH <u>Oct. 16 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>road construction Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William House</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fairble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-09-8207</u>	
17. INFORMANT <u>Dorothy Hines</u>		Address <u>Burkittsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound</u> DUE TO (c) <u>5 hours</u> 5 hours		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself with .22 rifle into right temporal region</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30 a.m. Oct 16 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Burkittsville</u> (County) <u>Frederick</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct. 16, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Locust Valley Ch. of the Com.</u>		22d. LOCATION (City, town, or county) <u>Fred Co.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladihill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>Elizabeth Y. Heck</u>	
ADDRESS <u>Gladihill Co., Middletown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Y. Heck</u>	

DEATH BOND

BUREAU V. S.

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10645

Item 18 Film 222 10-31-57

10636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jacqueline Hubbard				4. DATE OF DEATH Month Day Year October 7 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 3, 1954	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Malcon William Hubbard				14. MOTHER'S MAIDEN NAME Mary Tøryer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Malcon William Hubbard Address 505 Virginia Ave Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post Operative - Tonsillectomy DUE TO (c) Enlarged and infected tonsils							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 7 1957			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 10-9-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 9 Oct 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

BUREAU VI

10 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10646

10637

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Mt. Olivet Boulevard				d. STREET ADDRESS 14 Mt. Olivet Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle McKinney Last Johnson				4. DATE OF DEATH Month Oct. Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XXX WIDOWED XXX		8. DATE OF BIRTH Jan. 18-1871	
9. AGE (In years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew McKinney		14. MOTHER'S MAIDEN NAME Maria Gillmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Clyde B. Johnson-14 Mt. Olivet Blvd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Oct. 23 , 19 57 , that I last saw the deceased alive on Oct 23 , 19 57 , and that death occurred at 9:45PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church St. DATE SIGNED ACTUAL SIGNATURE Dr. R. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Frederick-Maryland							
22a. BURIAL-CREMATATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 10-26-1957		22c. NAME OF CEMETERY OR CREMATORY Frederick Mem. Park		22d. LOCATION (City, town, or county) (State) W. of Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE 26 Oct. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Registration		Place of Registration		Signature of Registrar	

BUREAU V. S.

Oct 29 1957

RECEIVED

10638

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Since 9-18-57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 1 Near Feagaville			
3. NAME OF DECEASED (Type or print) First GEORGE Middle HOFFMEIER Last KEFAUVER				4. DATE OF DEATH Month October Day 6 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 July 1879		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Laborer		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver H. Kefauver				14. MOTHER'S MAIDEN NAME Martha Ellen Nikirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Edgar L. Hargett (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452x Route exsanguination DUE TO (b) Aneurysm of subclavian artery DUE TO (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/25, 1952 to 10/6, 1957 , that I last saw the deceased alive on 10/7, 1957 , and that death occurred at 7:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 10-8-57							
ACTUAL SIGNATURE James B. Thomas		PHYSICIAN'S NAME (Type) James B. Thomas, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-57		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 9 Oct 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10639

CERTIFICATE OF DEATH

10648

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS RFD #2, Harpers Ferry, W.Va.	
3. NAME OF DECEASED (Type or print) PAUL D. LAYMAN		4. DATE OF DEATH Oct. 8 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Foundry	
11. BIRTHPLACE (State or foreign country) Howard County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas Layman		14. MOTHER'S MAIDEN NAME Alberta Price Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. About 1920-24 218-12-8097	
17. INFORMANT Mrs. Anne Butts Layman		18. ADDRESS (Street, city or town, state) RFD #2, Harpers Ferry, West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Polycythemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polycythemia			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 7, 1957 , to Oct. 8, 1957 , that I last saw the deceased alive on Oct. 8, 1957 , and that death occurred at 10:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		DATE SIGNED 10/8/57	
PHYSICIAN'S NAME (Type) A. A. Pearre		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/57	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	22d. LOCATION (City, town, or county) (State) Loudoun County, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE D. Donald Eckler		24a. REC'D BY REGISTRAR 14 Oct 1957	
ADDRESS Harpers Ferry, W.Va.		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

5502

2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 26

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OCT 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10640

CERTIFICATE OF DEATH

10649

Reg. Dist. No. 131

| | | | | | | | |
|---|-------------------------------|--|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 West Fifth Street | | | | d. STREET ADDRESS 2 West Fifth Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last Little | | | | 4. DATE OF DEATH Month Oct. Day 18 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> Never married | 8. DATE OF BIRTH 3-26-1889 | | 9. AGE (In years last birthday) 68 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder | | 10b. KIND OF BUSINESS OR INDUSTRY Iron Foundry | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James A. Little | | | | 14. MOTHER'S MAIDEN NAME Margaret Delozier | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWar 1 | | 16. SOCIAL SECURITY NO. 214-10-3247 | | 17. INFORMANT Albert C. Sprankle- 633 Grant Pl.-Frederick-Md Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of nasopharynx
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 12 months | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 15 , 19 56 , to Oct 18 , 19 57 , that I last saw the deceased alive on Oct 17 , 19 57 , and that death occurred at 1 A. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE S. R. Schoolman | | | | ADDRESS (Street, city or town, state) 228 N. Market St. | | DATE SIGNED 10/18/57 | |
| PHYSICIAN'S NAME (Type) Dr. L.R. Schoolman | | | | Frederick-Maryland | | | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial | | 22b. DATE THEREOF 10-21-1957 | | 22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick- Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick-Maryland | | | | 24a. REC'D BY REGISTRAR 19 Oct 1957 | | 24b. REGISTRAR'S SIGNATURE Elizabeth B. Herb | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| NAME OF DECEASED
James A. Little | | SEX
Male | | DATE OF BIRTH
1882-1882 | | PLACE OF BIRTH
Iron County, Tennessee | | CITY OF BIRTH
Iron County, Tennessee | | CITY OF DEATH
Baltimore, Maryland | |
| DATE OF DEATH
Oct 22 1957 | | PLACE OF DEATH
Baltimore, Maryland | | CITY OF DEATH
Baltimore, Maryland | | CITY OF DEATH
Baltimore, Maryland | | CITY OF DEATH
Baltimore, Maryland | | CITY OF DEATH
Baltimore, Maryland | |
| CAUSE OF DEATH
Heart Disease | | CAUSE OF DEATH
Heart Disease | | CAUSE OF DEATH
Heart Disease | | CAUSE OF DEATH
Heart Disease | | CAUSE OF DEATH
Heart Disease | | CAUSE OF DEATH
Heart Disease | |
| MANNER OF DEATH
Natural | | MANNER OF DEATH
Natural | | MANNER OF DEATH
Natural | | MANNER OF DEATH
Natural | | MANNER OF DEATH
Natural | | MANNER OF DEATH
Natural | |
| OCCUPATION
None | | OCCUPATION
None | | OCCUPATION
None | | OCCUPATION
None | | OCCUPATION
None | | OCCUPATION
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| EDUCATION
None | | EDUCATION
None | | EDUCATION
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None | | EDUCATION
None | |
| RELIGION
None | | RELIGION
None | | RELIGION
None | | RELIGION
None | | RELIGION
None | | RELIGION
None | |
| MARRIAGE
None | | MARRIAGE
None | | MARRIAGE
None | | MARRIAGE
None | | MARRIAGE
None | | MARRIAGE
None | |
| SIGNED BY
James A. Little | | SIGNED BY
James A. Little | | SIGNED BY
James A. Little | | SIGNED BY
James A. Little | | SIGNED BY
James A. Little | | SIGNED BY
James A. Little | |
| WITNESSED BY
James A. Little | | WITNESSED BY
James A. Little | | WITNESSED BY
James A. Little | | WITNESSED BY
James A. Little | | WITNESSED BY
James A. Little | | WITNESSED BY
James A. Little | |
| DATE
Oct 22 1957 | | DATE
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Oct 22 1957 | | DATE
Oct 22 1957 | |

BUREAU V. S.

OCT 22 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10650/

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10641

Items 3, 12 Film 222 11-4-57 et

Reg. Dist. No. 212

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dickerson R.F.D.2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Malcolm First MagLeod Middle MagLeod Last | | 4. DATE OF DEATH
October 25 Day 19 Year 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 4, 1924 |
| 9. AGE (In years last birthday)
33 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Ontario, Canada | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Murdouk MagLeod | | 14. MOTHER'S MAIDEN NAME
Catherine Montgomery | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
579-24-3584 | |
| 17. INFORMANT
Catherine Montgomery Dickerson R.F.D.2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis, Ileitis, Rupture Membranous
DUE TO Urethra. Fracture of superior and inferior rami of both pelvic bones. Fracture of right side of the sacral segments from first to 5 sacral segments
Conditions, if any, which gave rise to immediate cause (b) 824X
(c) right side of the sacral segments from first to 5 sacral segments
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driving a springler and apparent ranx his pelvis | | INTERVAL BETWEEN ONSET AND DEATH
2 days
7 days | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
over | |
| 20c. TIME OF INJURY
Month, Day, Year
11 Hour xx 10/17 57 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
High way | | 20f. (City or town) (County) Md. (State)
Dickerson R.D.2 Montgomery | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
B.O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
B.O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
October 25, | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct .29-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Parklawn | | 22d. LOCATION (City, town, or county) (State)
Rockville Pike, Rockville, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Constance C. Hilton | | ADDRESS
Barnesville, Maryland | |
| 24a. REC'D BY REGISTRAR
DATE 10/28/57 | | 24b. REGISTRAR'S SIGNATURE
Charles W. Elgin | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|----------------------------|--|--|--|
| NAME | | Frederick | |
| AGE | | 21 | |
| SEX | | Male | |
| RACE | | White | |
| DATE OF BIRTH | | October 10, 1934 | |
| PLACE OF BIRTH | | Catharine Montgomery Dickerson, D.C. | |
| DATE OF DEATH | | October 10, 1934 | |
| PLACE OF DEATH | | Catharine Montgomery Dickerson, D.C. | |
| CAUSE OF DEATH | | Acute myocardial infarction | |
| MANNER OF DEATH | | Natural | |
| SIGNATURE OF EXAMINER | | [Signature] | |
| TITLE OF EXAMINER | | Medical Examiner | |
| DATE OF EXAMINATION | | October 10, 1934 | |
| PLACE OF EXAMINATION | | Catharine Montgomery Dickerson, D.C. | |
| FAMILY HISTORY | | None | |
| SOCIAL HISTORY | | None | |
| HISTORY OF PRESENT ILLNESS | | Patient was well until October 10, 1934, when he experienced severe chest pain, which was relieved by rest and morphine. He died shortly thereafter. | |
| POST-MORTEM EXAMINATION | | None | |
| LABORATORY EXAMINATIONS | | None | |
| X-RAY EXAMINATIONS | | None | |
| TOXICOLOGICAL EXAMINATIONS | | None | |
| OTHER EXAMINATIONS | | None | |
| REMARKS | | None | |

BUREAU V. S.
OCT 30 1934

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10651

Reg. Dist. No.

131

| | | | | | | | |
|--|---|--|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Knoxville, Md. Frederick life | | | | c. LENGTH OF STAY IN 1b
life | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Henry Last McDuel | | | | 4. DATE OF DEATH
Month October Day 9 Year 19 57 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/14/1877 | | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS.
Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
USA Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John McDuel | | | | 14. MOTHER'S MAIDEN NAME
Anne Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
220-34-0731 | | 17. INFORMANT
Address Wm. Staley, (Cousin) Knoxville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rupture of aneurysm of left common iliac artery.
DUE TO arterio-sclerosis five years.
Conditions, if any, which gave rise to immediate cause (b) Hemorrhage
(a), stating the underlying cause last. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) B. O. Thomas, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Oct. 9, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-12-57 | 22c. NAME OF CEMETERY OR CREMATORY
St. Lukes | | 22d. LOCATION (City, town, or county) (State)
Brownsville, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
B. P. Tub | | | | 24a. REC'D BY REGISTRAR
10/9/57 | | 24b. REGISTRAR'S SIGNATURE
Clay G. Kelly | |
| ADDRESS
Brunswick, Maryland | | | | DATE | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Time of Death | | Place of Death | |
| Cause of Death | | Manner of Death | | Occupation | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |

12-31-1957

BUREAU V. S.

OCT 30 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 10-25-57 et

CERTIFICATE OF DEATH

10652

Reg. Dist. No. 131

10643

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | | c. LENGTH OF STAY IN 1b
Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
708 North Market Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ANNA MARIE LOUISE McSWEENEY | | | | 4. DATE OF DEATH
Month October Day 18 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
14 May 1866 | |
| 9. AGE (In years last birthday) 91 7/8 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House-work | | 11. BIRTHPLACE (State or foreign country)
Berlin, Germany | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Deceased | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cornary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Oct. 11 , 19 57 , to Oct. 18 , 19 57 , that I last saw the deceased alive on Oct. 17 , 19 57 , and that death occurred at 9:30 A .M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D. | | | | ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 10-18-57 | | | |
| PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
10-18-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State)
Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE 18 Oct. 1957 | | 24b. REGISTRAR'S SIGNATURE
Elizabeth G. Heck | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| John J. Jones | | Male | | 65 | | Jan 15, 1890 | | Baltimore, Md. | |
| MARRIAGE | | MARRIED | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | |
| Married | | Married | | Jan 15, 1915 | | Baltimore, Md. | | Mary J. Jones | |
| OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | |
| Retired | | Retired | | Retired | | Retired | | Retired | |
| CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | |
| Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | |
| MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | |
| Natural | | Natural | | Natural | | Natural | | Natural | |
| DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | |
| Oct 10, 1957 | | Oct 10, 1957 | | Oct 10, 1957 | | Oct 10, 1957 | | Oct 10, 1957 | |
| PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | |
| Home | | Home | | Home | | Home | | Home | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | |
| SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | |
| J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | |

BUREAU V. 2

OCT 21 1957 -

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10653

Reg. Dist. No. 131

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. LENGTH OF STAY IN 1b
Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
20 South Bentz Street | | | | d. STREET ADDRESS
20 South Bentz Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Clayton Franklin Augustus Parker | | | | 4. DATE OF DEATH
Month Day Year
October 11, 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 12, 1891 | |
| 9. AGE (In years last birthday)
66 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | 13. FATHER'S NAME
Clayton Parker | | | |
| 14. MOTHER'S MAIDEN NAME
Fannie | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address
Anna Mae Green, Frederick, Md., daughter | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
4 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<i>Robert J. Furie</i> | | | | DATE SIGNED
11 October 1957 | | | |
| EXAMINER'S NAME (Type)
Robert J. Furie, M. D. Acting | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-14-57 | | 22c. NAME OF CEMETERY OR CREMATORY
FAIRVIEW | | 22d. LOCATION (City, town, or county) (State)
Frederick - Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Hicks | | | | ADDRESS
Fred. Md. | | 24a. REC'D BY REGISTRAR
DATE 14 Oct. 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Elizabeth G. Heck</i> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John Doe | | Male | | 45 | | Oct 15, 1957 | |
| Place of Birth | | Occupation | | Cause of Death | | Manner of Death | |
| New York City | | Teacher | | Heart Disease | | Natural | |
| Residence | | Place of Death | | Physician's Name | | Hospital Name | |
| 123 Main St. | | 456 Oak St. | | Dr. J. Smith | | St. Mary's | |
| Signature of Examiner | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

OCT 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10645

CERTIFICATE OF DEATH

Reg. Dist. No.

10654
131

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. LENGTH OF STAY IN 1b
Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
417 Klineharts Alley | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle LEWIS Last PERKINS | | 4. DATE OF DEATH
Month October Day 31 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12 April 1900 |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer-Sewer Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY
City of Frederick | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry A. Perkins | | 14. MOTHER'S MAIDEN NAME
Sarah Catherine O'Brien | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-10-9675 | |
| 17. INFORMANT
Mrs. Marceline P. Riley | | 9786TU, Fort Detrick, Frederick, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain thrombosis
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Brain child Asthma
(c) Arterio-sclerotic Heart Dis. | | INTERVAL BETWEEN ONSET AND DEATH
1 day
2 years
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
491x Hypothyroidism | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5:10 , 19 57 , to 10-31 , 19 57 , that I last saw the deceased alive on 10-29 , 19 57 , and that death occurred at 4:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4 W. 3rd St., Frederick, Md. DATE SIGNED 11-1-57
ACTUAL SIGNATURE Thomas E. Stone M.D.
PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-2-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR
DATE 1 Nov 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Elizabeth G. Heck | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--------------------------|--|------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|--------------------------|--|--------------------------------|--|---------------------------|--|-----------------------------|--|------------------------|--|--------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1912 | | New York City | | New York City | | Heart Disease | | Jan 15, 1957 | | 10:00 AM | | Home | | Dr. J. Smith | | J. Doe | |
| Occupation | | Marital Status | | Color | | Height | | Weight | | Education | | Previous Illnesses | | Alcohol Consumption | | Tobacco Use | | Other Habits | | Remarks | | | |
| Teacher | | Married | | White | | 5'8" | | 170 lbs | | High School | | None | | Occasional | | Daily | | None | | | | | |
| Signature of Deceased | | Signature of Next of Kin | | Signature of Physician | | Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Pathologist | | Signature of Forensic Examiner | | Signature of Toxicologist | | Signature of Bacteriologist | | Signature of Chemist | | Signature of Radiologist | |
| | | | | | | | | | | | | | | | | | | | | | | | |

RECEIVED
 NOV 4 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648

CERTIFICATE OF DEATH

Reg. Dist. No. 10655

| | | | | | | | |
|---|---------------------------|--|-------------------------------------|--|-----------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u> | | | | d. STREET ADDRESS <u>MAIN ST</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edna Viola Rentzel</u> | | | | 4. DATE OF DEATH <u>Oct 10 1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 23-1888</u> | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HAMILTON SLICK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE BOLLINGER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>MRS CEDWARD MYERS UNIONTOWN MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with infarction of brain</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u>
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/7</u> 1957 to <u>10/10</u> 1957, that I last saw the deceased alive on <u>10/9</u> 1957, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>4 E. Church St</u> | | DATE SIGNED <u>10/10/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> | | | | <u>Frederick Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>OCT 13-1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u> | | 22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u> ADDRESS <u>New Windsor, Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 14 Oct 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 16 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10656

10667

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lantz -- rural | | | | c. LENGTH OF STAY IN lb
50 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CORA Middle LEWIS Last RIDENOUR | | | | 4. DATE OF DEATH
Month October Day 22 Year 1957 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 19, 1879 | 9. AGE (In years last birthday) yrs. 78 | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel W. Lewis | | | | 14. MOTHER'S MAIDEN NAME
Catherine Toms | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Earl Ridenour | | Address
Lantz, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 2 Yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m.
19 | Month, Day, Year
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from 5/23 , 19 57 , to 10/22 , 19 57 , that I last saw the deceased alive on 10/19 , 19 57 , and that death occurred at 1:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 10/22/57 | | | | | | | |
| ACTUAL SIGNATURE Charles F. Hess M.D. | | | | DATE SIGNED 10/22/57 | | | |
| PHYSICIAN'S NAME (Type) Dr. Charles F. Hess Smithsburg, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10- 25-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Bethel M.E. Cem | | 22d. LOCATION (City, town, or county) (State)
Nr. Garfield Fredk Co. MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Creager | | | | ADDRESS
Thurmont, Maryland | | 24a. REC'D BY REGISTRAR
DATE OCT 25 '57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
[Signature] | | | |

Interest rates

1929

81252179

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10647

CERTIFICATE OF DEATH

106571

Reg. Dist. No. 144

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | | c. LENGTH OF STAY IN 1b
5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Frederick Memorial Hospital | | | | e. STREET ADDRESS
123 East Potomac Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Mrs Ethel Middle Roberson Last
4. DATE OF DEATH
Month Oct Day 30 Year 1957 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 28, 1917 | 9. AGE (In years last birthday)
39 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Brunswick | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert M. Anderson | | | | 14. MOTHER'S MAIDEN NAME
Sadie N. Martin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Sadie M. Anderson | | Address
Brunswick | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-Pneumonia
241X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) Status Asthmaticus DUE TO
(c) — | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 647X Parturition at term 10/27/57 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | | | |
| 21. I certify that I attended the deceased from Oct 25, 1957 , to Oct 30, 1957 , that I last saw the deceased alive on Oct 30, 1957 , and that death occurred at 5 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A A Gessre M.D. | | | | ADDRESS (Street, city or town, state) Fredrick, Md | | DATE SIGNED 10/30/57 | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 2 | | 22c. NAME OF CEMETERY OR CREMATORY
Park Heights | | 22d. LOCATION (City, town, or county) (State)
Brunswick Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Elva V. Tate Brunswick Md | | | | 24a. REC'D BY REGISTRAR
DATE 11-2-57 | | 24b. REGISTRAR'S SIGNATURE
Eugene H. Bunch
Ely Hecker | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648

CERTIFICATE OF DEATH

10658

Reg. Dist. No. 131

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | |
| c. LENGTH OF STAY IN 1b
Days | | d. STREET ADDRESS
110 North Court Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First VINCENT Middle Last ROGERS | | 4. DATE OF DEATH
Month October Day 9 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 12, 1876 |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Owner | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | |
| 11. BIRTHPLACE (State or foreign country)
England | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry Rogers | | 14. MOTHER'S MAIDEN NAME
Harriett Roebuck | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Nena P. Rogers, 110 North Court Street, Frederick, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute posterior Coronary
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Ischemia
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hours
2 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1930 , to Oct 9 , 1957, that I last saw the deceased alive on Oct 9 , 1957, and that death occurred at 6:30 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Professional Bldg., 10/9/1957 | | | |
| ACTUAL SIGNATURE B. O. Thomas | | M.D. Professional Bldg., 10/9/1957 | |
| PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr. | | Frederick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Entombment | 22b. DATE THEREOF
Oct. 12, 1957 | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cloister Woodlawn Cem., New York, | 22d. LOCATION (City, town, or county) (State)
New York |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | ADDRESS
Frederick, Maryland | |
| 24a. REC'D BY REGISTRAR
DATE 11 Oct, 1957 | | 24b. REGISTRAR'S SIGNATURE
Elizabeth G. Heck | |

15 22000428-NY124 30 21010493 STATE DEPARTMENT

OCT 14 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

10649

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | | c. LENGTH OF STAY IN 1b
41 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
606 Rosemont Avenue | | | | e. STREET ADDRESS
606 Rosemont Avenue | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle CARSON Last ROYAL | | | | 4. DATE OF DEATH
Month October Day 14 , Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
30 Aug 1885 | |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Clergyman | | 11. BIRTHPLACE (State or foreign country)
Jackston, North Carolina | |
| 13. FATHER'S NAME
Richard Royal | | | | 14. MOTHER'S MAIDEN NAME
Jane Barbour | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Nellie E. Royal (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertenison
331x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town)
(County)
(State) | | | |
| 21. I certify that I attended the deceased from June , 19 51 , to October 14 , 19 57 , that I last saw the deceased alive on October 14 , 19 57 , and that death occurred at 3:10P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 9 E. Church St., Frederick, Md. DATE SIGNED 10-15-57 | | | | | | | |
| ACTUAL SIGNATURE
H. J. Slusher M.D. | | | | PHYSICIAN'S NAME (Type) H. J. Slusher, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-16-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE 17 Oct 1957 | | 24b. REGISTRAR'S SIGNATURE
Elizabeth G. Heck | |

MARIANO STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

OCT. 21. 1957

RECEIVED

10650
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

10660
 Reg. Dist. No. 131

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick Memorial Hospital | | d. STREET ADDRESS
16 Carver Apts | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Delia Middle Bell Last Saunders | | 4. DATE OF DEATH
Month Oct. Day 31 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 25- 1884 |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY
Dress Maker | |
| 11. BIRTHPLACE (State or foreign country)
Frederick- Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William Wise | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Franklin Saunders | | Address
16 Carver Apts. Fred. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
(c) Chronic Disease | | | INTERVAL BETWEEN ONSET AND DEATH
1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct 15, 1957 to Oct 31, 1957 , that I last saw the deceased alive on Oct 31, 1957 , and that death occurred at 12:15 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4 East Church St. Frederick, Md.
DATE SIGNED Nov 1, 1957 | | | |
| ACTUAL SIGNATURE E.P. Thomas | | M.D. | |
| PHYSICIAN'S NAME (Type) E.P. Thomas M.D. | | 4 East Church St. Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Nov. 2-57 | 22c. NAME OF CEMETERY OR CREMATORY
Fairview | 22d. LOCATION (City, town, or county) (State)
Frederick, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Hicks III | | ADDRESS
Frederick, Md. | |
| 24a. REC'D BY REGISTRAR
Mr. 1957 | | 24b. REGISTRAR'S SIGNATURE
Elizabeth S. Hark | |

10668

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lantz | | | | c. LENGTH OF STAY IN 1b
18 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
Lantz | | | |
| 3. NAME OF DECEASED
(Type or print) William George Seipler | | | | 4. DATE OF DEATH
Month Oct. Day 22. Year 1957 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 18, 1910 | |
| 9. AGE (In years last birthday)
47 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own business | | 11. BIRTHPLACE (State or foreign country)
Penna. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Assard Seipler | | | | 14. MOTHER'S MAIDEN NAME
Catherine Fillers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
219-01-8277 | | | |
| 17. INFORMANT
Mrs. Dorothy R. Seipler, Lantz, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart disease - coronary type
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute indigestion
DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs.
2 hrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from Oct. 22, 1957 to Oct. 22, 1957 , that I last saw the deceased alive on Oct. 22, 1957 , and that death occurred at 1:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
James K. Gray M.D. | | | | DATE SIGNED
Thurmont - Md. 10/22/57 | | | |
| PHYSICIAN'S NAME (Type)
James K. Gray | | | | Thurmont - Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-25-57 | | 22c. NAME OF CEMETERY OR CREMATORY
United Brethern Cem. | | 22d. LOCATION (City, town, or county) (State)
Thurmont, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Creager | | | | ADDRESS
Thurmont, Md. | | | |
| 24a. REC'D BY REGISTRAR
Oct 25 57 | | | | 24b. REGISTRAR'S SIGNATURE
W. H. Beach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| PLACE OF BIRTH | | PLACE OF DEATH | |
| BALTIMORE, MARYLAND | | BALTIMORE, MARYLAND | |
| DATE OF BIRTH | | DATE OF DEATH | |
| JAN. 1, 1910 | | JAN. 1, 1910 | |
| AGE | | AGE | |
| 10 YRS. | | 10 YRS. | |
| SEX | | SEX | |
| MALE | | MALE | |
| RACE | | RACE | |
| WHITE | | WHITE | |
| OCCUPATION | | OCCUPATION | |
| COW BOY | | COW BOY | |
| CAUSE OF DEATH | | CAUSE OF DEATH | |
| Cerebral Palsy | | Cerebral Palsy | |
| MANNER OF DEATH | | MANNER OF DEATH | |
| NATURAL | | NATURAL | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| J. H. [Signature] | | J. H. [Signature] | |
| DATE | | DATE | |
| JAN. 1, 1910 | | JAN. 1, 1910 | |
| LOCAL HEALTH OFFICER | | LOCAL HEALTH OFFICER | |
| [Signature] | | [Signature] | |
| DATE | | DATE | |
| JAN. 1, 1910 | | JAN. 1, 1910 | |

BUREAU V. 3

OCT. 25 1957

RECEIVED

Lyndon B. Johnson Library

10669

CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Kemptown | | | | c. LENGTH OF STAY IN 1b
Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
R.F.D. Monrovia | | | | d. STREET ADDRESS
R.F.D. Monrovia | | | |
| 3. NAME OF DECEASED (Type or print)
First Odie Middle Dorsey Last Sier | | | | 4. DATE OF DEATH
Month October Day 10 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 1, 1883 | 9. AGE (In years last birthday) yrs.
74 | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Frederick Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Upton Sier | | | | 14. MOTHER'S MAIDEN NAME
Laura Clay | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Howard L. Sier, Monrovia, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the stomach with generalized metastases
DUE TO 151x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) metastases
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. n. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 10, 1957 , to October 10, 1957 , that I last saw the deceased alive on October 8, 1957 , and that death occurred at 11:30 PM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James P. Kerr | | | | ADDRESS (Street, city or town, state)
Damascus, Md. | | DATE SIGNED
10/12/57 | |
| PHYSICIAN'S NAME (Type)
James P. Kerr | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 13, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Providence | | 22d. LOCATION (City, town, or county) (State)
Kemtown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Clint L. Molanuth | | | | ADDRESS
Damascus, Md. | | 24a. REC'D BY REGISTRAR
DATE 10/15/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Raymond F. Day | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957 21 NOV

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10670

CERTIFICATE OF DEATH

Reg. Dist. No. 139

10662

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CULLEN, MD.</u> | | c. LENGTH OF STAY IN 1b
<u>18 Mo + 3 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CUMBERLAND, MD. 01022</u> | | d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>VICTOR CULLEN STATE HOSPITAL, MARYLAND</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
<u>723 VIRGINIA AVE, CUMBERLAND</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Maggie</u> Middle <u>LAURA</u> Last <u>SMITH</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>29</u> Year <u>1957</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/20/1885</u> |
| 9. AGE (In years last birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>W. V.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>DANIEL CRIST.</u> | | 14. MOTHER'S MAIDEN NAME
<u>ABBIE MONGOL.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | |
| 17. INFORMANT
<u>RECORD OF VICTOR CULLEN STATE HOSPITAL.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Active pulmonary tuberculosis</u>
<u>002X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 19</u> , 19 <u>56</u> , to <u>Oct. 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 22</u> , 19 <u>57</u> , and that death occurred at <u>2:55 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Cullen, Md.</u> DATE SIGNED <u>10/22/57</u>
ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D.
PHYSICIAN'S NAME (Type) <u>T. F. Vestal, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-24-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Meadow Point</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Keyser, West Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Allen M. Rotnick</u> | | ADDRESS
<u>Keyser, W. Va.</u> | |
| 24a. REC'D BY REGISTRAR
<u>Oct 24 57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Allen M. Rotnick</u> | |

BUREAU V. S.

24 OCT 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10651

CERTIFICATE OF DEATH

Reg. Dist. No.

10663

131

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 67 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Magnolia Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First James Middle Elmer Last Solt | | | | 4. DATE OF DEATH Month Oct. Day 6th Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. ***** WIDOWED <input checked="" type="checkbox"/> ***** | | 8. DATE OF BIRTH 6-13-1869 | |
| 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR Months 8 Days 24 Hours 15 Min. | | IF UNDER 24 HRS. Hours 15 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Garage-Sales-Service | | | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Jacob B. Solt | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Frome | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Wm. H. Solt- Frederick-Md. (Son) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Ischemia
DUE TO
(c) 24 hrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Jan , 19 57 , to Oct 6 , 19 57 , that I last saw the deceased alive on Oct 6 , 19 57 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | | | Professional Bldg. | | | |
| PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Sr. | | | | Frederick- Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cliver Son ADDRESS Frederick-Md. | | | | 24a. REC'D BY REGISTRAR 10 Oct 1957 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck | |

RECEIVED
OCT 14 1957
BUREAU V. S.

BUREAU V. 51

OCT 14 1957

RECEIVED

10653 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

10664

Reg. Dist. No. 141

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY FREDERICK. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BRUNSWICK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
35 BRUNSWICK | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
NELLIE ESTELLE STREAMS | | 4. DATE OF DEATH
Month Day Year
October 13 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 7, 1903 |
| 9. AGE (In years last birthday)
54 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM H. BARBER | | 14. MOTHER'S MAIDEN NAME
ALICE H. DRUMMER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
N.O. | | 16. SOCIAL SECURITY NO.
722-12-3305 | |
| 17. INFORMANT
GEORGE S. STREAMS, | | Address
(husband.) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis
DUE TO 705.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lupus erythematosus
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
Month
2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 10/8 , 19 55 , to 10/13 , 19 57 , that I last saw the deceased alive on 10/8 , 19 57 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
JAMES B. THOMAS | | M.D. 228 N. Market St. Frederick, Md. | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED
10/13/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
Oct. 16, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Petersville Cemetery | | 22d. LOCATION (City, town, or county) (State)
Petersville, Frederick, Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert E. Dailey Jr. | | ADDRESS
Frederick, Md. | |
| 24a. REC'D BY REGISTRAR
15 Oct, 1957 | | 24b. REGISTRAR'S SIGNATURE
Eugenia Burke | |

BUREAU V. S.

OCT 16 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10665

10671

CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md b. COUNTY Frederick | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick Rural | | | | c. LENGTH OF STAY IN 1b
60 yrs | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick R.D. (Hansonville) | | | | | |
| d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
DAISY SUSSANNA STULL | | | | 4. DATE OF DEATH Month Day Year
Oct. 31. 1957 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 11, 1882 | | | |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME
John P. Wachter | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Fout | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Earl Hill Address Fredrick, Md. RD 3 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line from (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chorea | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I attended the deceased from 1927 to Oct. 26, 1957 , that I last saw the deceased alive on Oct 26, 1957 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE
H.F. Kline M.D. | | | | ADDRESS (Street, city or town, state)
Fredrick Md DATE SIGNED
Nov 15 1957 | | | | | |
| PHYSICIAN'S NAME (Type) H.F. Kline Sr. 7 N. Market. Frederick MD | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-2-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Charlesville Zion Cem. Charlesville, Maryland | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Creager ADDRESS Thurmont, Maryland | | | | 24a. REC'D BY REGISTRAR
Nov 5 1957 | | 24b. REGISTRAR'S SIGNATURE
Ely Black | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10665,
21

10652

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frederick</u> | | c. LENGTH OF STAY IN 1b
<u>12 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>Frederick Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>CALVIN</u> Middle <u>E</u> Last <u>TROXELL</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>21</u> Year <u>1957</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-7-94</u> |
| 9. AGE (In years last birthday)
<u>63</u> yrs. | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own farm</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JACOB L. TROXELL</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY ANN BARTON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
Address
<u>Mrs. Leslie Fox</u> <u>Rocky Ridge, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u>
<u>177x</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Extensive Metastases</u>
DUE TO
(c) <u>Uremia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2-3 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u>
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-9-</u> , 19 <u>57</u> , to <u>10-21-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-21-</u> , 19 <u>57</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert S. Crouch</u> M.D. | | ADDRESS (Street, city or town, state) <u>101 Frederick Shopping Center</u> | |
| PHYSICIAN'S NAME (Type) <u>ROBERT D. CROUCH</u> | | DATE SIGNED <u>10/21/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-24-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Apple's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Nr. Thurmont, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Raymond E. Creager</u> | | ADDRESS
<u>Thurmont, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>DATE 25 1957</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Ely Hicks</u> | |

BUREAU A. F.

1957 25 OCT

RECEIVED

64. 3000000

“YOUNG” . . . “OLD”

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10653

CERTIFICATE OF DEATH

Reg. Dist. No.

10667

131

| | | | | | |
|---|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | c. LENGTH OF STAY IN 1b
2 wks. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick Mem. Hospital | | | d. STREET ADDRESS
R.D. 1 Mt. Airy | | |
| 3. NAME OF DECEASED (Type or print)
First Bessie Middle A. Last Watkins | | | 4. DATE OF DEATH
Month Oct Day 8 Year 1957 | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-29-1886 | | 9. AGE (In years last birthday)
71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housework | | 10b. KIND OF BUSINESS OR INDUSTRY
home | | 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
Dennis W. Lowman | | | 14. MOTHER'S MAIDEN NAME
Etta V. Long | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-204523 | | 17. INFORMANT
Mrs. Paul Snyder, Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis / Heart disease
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
8-10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from 9/24 , 19 57 , to 10/8 , 19 57 , that I last saw the deceased alive on 10/7 , 19 57 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
Henry V. Chase | | ADDRESS (Street, city or town, state)
4 E. Church St | | DATE SIGNED
10/8/57 | |
| PHYSICIAN'S NAME (Type)
Henry V. Chase | | Frederick Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
10-11-1957 | 22c. NAME OF CEMETERY OR CREMATORY
Pine Grove | 22d. LOCATION (City, town, or county) (State)
Mt. Airy, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz, | | | ADDRESS
Winfield, Maryland | | |
| 24a. REC'D BY REGISTRAR
10/10/57 | | 24b. REGISTRAR'S SIGNATURE
Elizabeth Heck | | | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
[Faint text] | | 2. SEX
[Faint text] | | 3. AGE
[Faint text] | |
| 4. PLACE OF BIRTH
[Faint text] | | 5. PLACE OF DEATH
[Faint text] | | 6. DATE OF DEATH
[Faint text] | |
| 7. OCCUPATION
[Faint text] | | 8. CAUSE OF DEATH
[Faint text] | | 9. MANNER OF DEATH
[Faint text] | |
| 10. SIGNATURE OF PHYSICIAN
[Faint text] | | 11. SIGNATURE OF WITNESS
[Faint text] | | 12. SIGNATURE OF DECEASED
[Faint text] | |
| 13. SIGNATURE OF REGISTRAR
[Faint text] | | 14. SIGNATURE OF CLERK
[Faint text] | | 15. SIGNATURE OF CHIEF OF BUREAU
[Faint text] | |

BUREAU M.H.

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10654
CERTIFICATE OF DEATH

Reg. Dist. No. 131

10668

| | | | |
|--|---------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN b 8 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial | | e. STREET ADDRESS Sunnyside- Frederick Co. Md. | |
| 3. NAME OF DECEASED (Type or print) First James Middle Monroe Last Weedon | | 4. DATE OF DEATH Month Oct Day 21 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 11-1881 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 11. BIRTHPLACE (State or foreign country) Frederick, Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Thomas Jefferson Weedon | | 14. MOTHER'S MAIDEN NAME Louise Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-05-5062 | |
| 17. INFORMANT Daisy M. Weedon | | Address Rt. 4 Frederick, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic adenocarcinoma of colon
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 34 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Empyema | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/21 , 19 57 , to 10/21 , 19 57 , that I last saw the deceased alive on 10/21 , 19 57 , and that death occurred at M , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE James B. Thomas M.D. | | Professional Building Frederick, Md. | |
| PHYSICIAN'S NAME (Type) James B. Thomas M.D. | | Professional Building Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-25-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Joseph Catholic | | 22d. LOCATION (City, town, or county) (State) Carrollton Manor Fred. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks | | ADDRESS 111 Frederick, Md. | |
| 24a. REC'D BY REGISTRAR 24 Oct 1957 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|-----------------------|--|--------------------------|--|------------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES L. WOODS, JR. | | 35 | | M | | W | | 1924 | | BALTIMORE, MD. | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | DATE OF DEATH | | PLACE OF DEATH | |
| DRIVER | | HIGH SCHOOL | | MARRIED | | METHODIST | | OCT 28 1957 | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | | REGISTRATION NO. | | DATE OF REGISTRATION | | PLACE OF REGISTRATION | |
| HEART DISEASE | | NATURAL | | 100-01-1234 | | 100-01-1234 | | OCT 28 1957 | | BALTIMORE, MD. | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF BURIAL OFFICIAL | |
| JAMES L. WOODS, JR. | | JAMES L. WOODS, JR. | | JAMES L. WOODS, JR. | | JAMES L. WOODS, JR. | | JAMES L. WOODS, JR. | | JAMES L. WOODS, JR. | |

BUREAU V. 2

OCT 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10655

CERTIFICATE OF DEATH

Reg. Dist. No.

10669

131

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. LENGTH OF STAY IN 1b
2 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick County Chronic Hospital | | e. STREET ADDRESS
1 Yellow Springs | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle HENRY Last WILES | | 4. DATE OF DEATH
Month October Day 9 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 9, 1875 |
| 9. AGE (In years last birthday) yrs. 82 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Coleman R. Wiles | | 14. MOTHER'S MAIDEN NAME
Sarah Shankle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
214-14-7553 | |
| 17. INFORMANT
Mr. Alvie C. Wiles, Frederick R.F.D.#3, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myoplegia
DUE TO
(c) Arterio Sclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
4 1/2 yrs.
3 yrs.
4 1/2 yrs. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 54 to Oct 7 , 19 57 , that I last saw the deceased alive on Oct 7 , 19 57 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) North Market Street, Frederick, Maryland
DATE SIGNED 10/12/1957
ACTUAL SIGNATURE H. F. Kline, Sr.
PHYSICIAN'S NAME (Type) Dr. H. F. Kline, Sr.
Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify)
Burial | | 22b. DATE THEREOF
Oct. 12, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR
14 Oct 1957
24b. REGISTRAR'S SIGNATURE
Elizabeth G. Heck | |

BUREAU V. S.

1957 16 150

RECEIVED

10656

CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u> <u>06 x 2.2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>James D. Windsor</u> | | 4. DATE OF DEATH <u>10 22 1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-29-1885</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>house</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Harry Windsor</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Kaine</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-12-1297</u> | |
| 17. INFORMANT <u>Mrs. Mary Laura Windsor,</u> Address <u>Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with congestive failure</u>
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>10/21</u> , 19 <u>57</u> , to <u>10/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/22</u> , 19 <u>57</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. A. Pearre</u> | | ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>10/22/57</u> | |
| PHYSICIAN'S NAME (Type) <u>A. A. Pearre</u> | | <u>Frederick Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>10-25-1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u> | 22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u> | | 24a. REC'D BY REGISTRAR <u>10/25/57</u> 24b. REGISTRAR'S SIGNATURE <u>Elyse H. Beck</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFERENCES

BUREAU V. S.

OCT 25 1957

RECEIVED

10657

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
c. LENGTH OF STAY IN lb Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 320 East Third Street | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
d. STREET ADDRESS 320 East Third Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First SOLOMAN Middle JOSEPH Last ZIMMERMAN | | 4. DATE OF DEATH
Month October Day 8 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10 July 1878 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet-maker | | 10b. KIND OF BUSINESS OR INDUSTRY Lumber Company | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Elton G. Zimmerman | | 14. MOTHER'S MAIDEN NAME Laura M. Zimmerman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-10-9142 | |
| 17. INFORMANT Karl W. Zimmerman Address (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO Arterio-sclerotic Heart dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (b) _____
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
6 HRS.
5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March , 19 55 , to 8 Oct , 19 57 , that I last saw the deceased alive on 27 Sept , 19 57 , and that death occurred at 5 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 10-9-57
ACTUAL SIGNATURE Charles H. Conley, Jr. M.D.
PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10-11-57 | 22c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery | 22d. LOCATION (City, town, or county) (State) Hamilton, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland ADDRESS | | 24a. REC'D BY REGISTRAR 11 Oct 1957 | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hack |

MEDICAL CERTIFICATION

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1957

BUREAU V. S.

RECEIVED